

**UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA**

IN RE: DIGITEK®
PRODUCT LIABILITY LITIGATION

Master Docket No.

MDL No. 1968

PLAINTIFF: Alan Chambers
(name)

AMENDED DIGITEK® PLAINTIFF FACT SHEET

Please provide the following information for each individual on whose behalf a claim is being made. Please answer every question to the best of your knowledge. In completing this Fact Sheet, you are under oath and must provide information that is true and correct to the best of your knowledge. If you cannot recall all of the details requested, please provide as much information as you can. You must supplement your responses if you learn that they are incomplete or incorrect in any material respect. If you are completing the Fact Sheet for someone who has died or who cannot complete the Fact Sheet him/herself, please answer as completely as you can for that person.

The Fact Sheet shall be completed in accordance with the requirements and guidelines set forth in the applicable Case Management Order. A completed Fact Sheet shall be considered interrogatory answers pursuant to Fed. R. Civ. P. 33 and as responses to requests for production pursuant to Fed. R. Civ. P. 34 will be governed by the standards applicable to written discovery under Fed. R. Civ. P. 26 through 37. The questions and requests for production contained in the Fact Sheet are non-objectionable and shall be answered without objection.

In filling out this form, please use the following definition: “healthcare provider” means any hospital, clinic, center, physician’s office, infirmary, medical or diagnostic laboratory, or other facility that provides medical care or advice, and any pharmacy, x-ray department, radiology department, laboratory, physical therapist or physical therapy department, rehabilitation specialist, chiropractor, or other persons or entities involved in the diagnosis, care and/or treatment of you.

In addition, to the extent that the form does not provide enough space to complete your responses or answers, please attach additional sheets as necessary.

I. CASE INFORMATION

1. Please state the following for the civil action that you filed:
 - a. Case caption: Alan Chambers v. Actavis Totowa, LLC (formerly known as Amide Pharmaceuticals, Inc.), Actavis, Inc., Actavis Elizabeth, LLC, Actavis US, Mylan, Inc., Mylan Pharmaceuticals, Inc., Mylan Laboratories, Inc., Mylan Bertek Pharmaceuticals Inc., and John Doe Defendants 1-20
 - b. Civil Action Number: L-1881-08
 - c. Court in which action was originally filed: Atlantic County

d. Your attorney:

Name: James J. Pettit, Esquire

Address: Locks Law Firm LLC, 457 Haddonfield Road, Suite 500, Cherry Hill, NJ 08002

2. Name of person completing this form: [REDACTED]

3. Please list any other names you have used or by which you have been known and dates you used those names: N/A

4. Your current address: [REDACTED]

5. If you are completing this Fact Sheet in a representative capacity (e.g., on behalf of the estate of a deceased person or a minor), please complete the following:

a. Describe the capacity in which you are representing the individual or estate: N/A

b. If you were appointed as a representative by a court, state the:

Court Which Appointed You: _____

Date of Appointment: _____

c. What is your relationship to the individual you represent: _____

d. If you represent a decedent's estate, state:

Decedent's Date of Death: _____

Address of Place Where Decedent Died: _____

e. If you are claiming the wrongful death of a family member, identify any and all family members, beneficiaries, heirs or next of kin of that person, including their relationship to Decedent:

N/A

THE REST OF THIS FACT SHEET REQUESTS INFORMATION ABOUT THE PERSON WHO PURCHASED, OR PURCHASED AND USED DIGITEK®. WHETHER YOU ARE COMPLETING THIS FACT SHEET FOR YOURSELF OR FOR SOMEONE ELSE, PLEASE ASSUME THAT "YOU" MEANS THE DIGITEK® PURCHASER OR PURCHASER AND USER.

II. CLAIM INFORMATION

1. Name of Digitek® Purchaser/User: [REDACTED]
2. Have you used any other names in the last five (5) years? Yes ☐ No ☒
If yes, please list any such names that you have used: _____
3. Do you claim that you suffered bodily injuries as a result of taking Digitek®?
Yes ☐ No ☒ If Yes, please answer the following:
 - a. What bodily injuries do you claim resulted from your use of Digitek®?

 - b. When is the first time you saw a health care provider for any of the symptoms you link to your alleged injury? _____
 - c. Are you currently experiencing symptoms related to your alleged injury?
Yes ☐ No ☐ If Yes, please describe the symptoms: _____
 - d. Did you see a doctor, clinic or healthcare provider for the bodily injuries or illness listed above?
Yes ☐ No ☐ If Yes, who: _____
 - e. Who diagnosed your injury? _____
 - f. Date of diagnosis: _____
 - g. Were you hospitalized?
Yes ☐ No ☐ If Yes, please answer the following:
 - 1) Date of hospital admission: _____
 - 2) Date of discharge: _____
 - 3) Hospital name and address: _____
 - h. What harm or consequence including physical limitations, do you claim you suffered as a result of the bodily injury above, excluding any mental or emotional damages, lost wages or out of pocket expenses listed below?

 - i. Do you claim that your injury was caused by ingesting defective Digitek® medication?

Yes ☐ No ☐ If Yes, please answer the following:

- 1) Describe in detail what you claim the defect to have been in the Digitek® medication that you ingested: _____
 - 2) How much of the defective product did you ingest? _____
 - 3) When did you ingest the product? _____
- j. Have you had any discussions with any doctor or other healthcare provider about whether Digitek® caused you to suffer any illness or injury?

Yes ☐ No ☐ If Yes, who:

4. Are you claiming mental and/or emotional damages as a result of taking Digitek®?

Yes ☐ No ☒

If Yes, what mental and/or emotional damages do you claim resulted from your use of Digitek®?

If Yes, for each provider (including but not limited to primary care physicians, psychiatrists, psychologists, and/or counselors) from whom you have sought treatment for psychological, psychiatric or emotional problems, state the following:

NAME	ADDRESS	CONDITION TREATED	DATES TREATED	MEDICATIONS PRESCRIBED

5. Are you making a claim for lost wages or lost earning capacity?

Yes ☐ No ☒ If Yes, state the annual gross income you derived from your employment for each of the last five (5) years:

6. Have you incurred any out-of-pocket expenses as a result of using Digitek®?

Yes ☒ No ☐ If Yes, please identify and itemize all out-of-pocket expenses you have incurred:
Plaintiff incurred medical and pharmacy co-pay expenses.

7. What other damages, if any, do you claim you suffered as a result of the purchase or ingestion of Digitek®?

Plaintiff was prescribed and ingested the recalled Digitek and claims he suffered economic loss as a result of purchasing the recalled Digitek.

III. DIGITEK® PRESCRIPTION INFORMATION

1. Have you ever used Digitek®? Yes ☒ No ☐
2. If you answered yes to No. 1, identify the following for each period of time during which you took Digitek®:

DOSAGE (.125 MG OR .250 MG)	HOW OFTEN PER DAY OR WEEK?	DATE STARTED	DATE STOPPED	NAME OF PRESCRIBER
.125 mg	Once per day	1/23/2008	4/30/2008	Dr. DeVender Akula

3. Name(s) and address(es) of pharmacies where prescriptions were filled: Rite Aid Pharmacy, 7835 Maple Avenue, Pennsauken, NJ 08109
4. Identify the condition for which you were prescribed Digitek®: To regulate heart rhythm

5. Did you receive any free samples of Digitek®?

Yes ☐ No ☒ If Yes, please state the following:

- a. Who provided the samples? _____
- b. When were samples provided? _____
- c. What was the dosage of the samples? _____
- d. How many samples were provided? _____

6. Do you have in your possession or does your attorney have the packaging from the Digitek® you allegedly purchased, or purchased and used, and/or any Digitek® tablets?

Yes ☐ No ☒

- a. If yes, who currently has custody of the Digitek® packaging and/or tablets?

- b. If you or your attorney is in possession of tablets, how many do you have? _____
- c. Have you or anyone on your behalf tested the Digitek® tablets in your possession?

Yes ☐ No ☐ If Yes,

- 1) Who tested the tablets? _____
- 2) What test(s) was performed? _____
- 3) How many tablets were tested? _____
- 4) When were the tests performed? _____
- 5) What were the test results? _____

(NOTE: In lieu of answering the following Question Nos. 7a and 7b, please attach a clear copy of the product packaging and/or the label on the vial or blister pack of Digitek® in your or your attorney's possession that provides the information sought below.)

7a. Do you know the lot number(s) for any of the Digitek® you received?

Yes ☐ No ☒

If Yes, what is/are the lot number(s): Plaintiff does not know the lot number but knows the NDC # is 62794014501

7b. Do you know the expiration date for any of the Digitek® you received?

Yes ☐ No ☒

If Yes, when is/was/were the expiration date(s): _____

8. Have you had any communication, oral or written, with any of the defendants or their representatives?

Yes ☐ No ☒

If Yes, set forth the date of the communication, the method of communication, the name of the person with whom you communicated, and the substance of the communication between you and any defendants or their representatives:

9. Have you ever used any other digoxin or digitalis product (i.e. Lanoxin)?

Yes ☒ No ☐

If Yes, please state:

DOSAGE (.125 MG OR .250 MG)	HOW OFTEN PER DAY OR WEEK?	DATE STARTED	DATE STOPPED	NAME OF PRESCRIBER
<input checked="" type="checkbox"/> .125 mg	Once per day	7/14/2008	Approx 8/2008	Dr. Gary Burke
<input type="checkbox"/> .250 mg				

<input type="checkbox"/> .125 mg				
<input type="checkbox"/> .250 mg				
<input type="checkbox"/> .125 mg				
<input type="checkbox"/> .250 mg				

10. Are you aware that Digitek® was recalled?

Yes ☒ No ☐ If Yes, please state the following:

- a. When you became aware of the recall: Approximately 5/2008.
- b. How you became aware of the recall: Plaintiff was told by his pharmacist.

11. Did you discuss the recall with any healthcare provider or pharmacist?

Yes ☒ No ☐ If Yes, please state the following:

- a. When that discussion occurred: Plaintiff does not recall when he spoke with Dr. Burke.
- b. With whom: Rite Aid pharmacist and Dr. Gary Burke

12. Did you return any Digitek® to Stericycle or any pharmacy?




Yes ☐ No ☒ If Yes, please state the following:

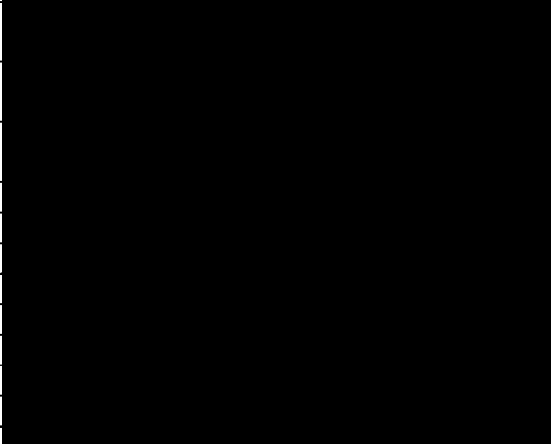
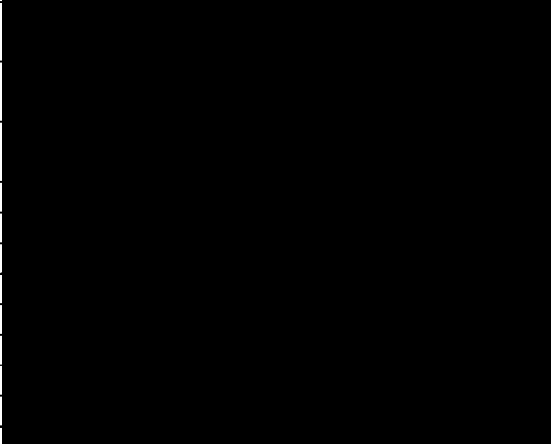
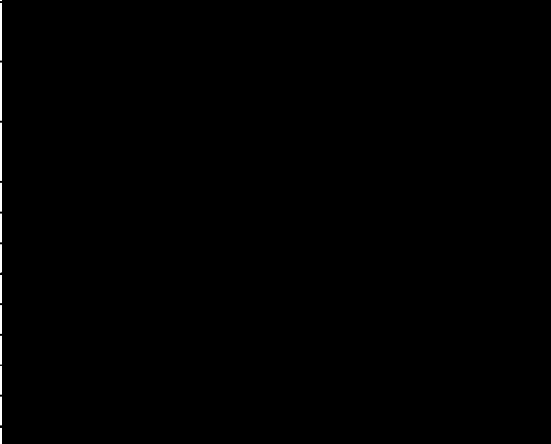
- a. When did you return the product? _____
- b. Do you have your paperwork regarding the return? Yes ☐ No ☐
- c. To whom did you return the product? _____

13. Have you ever visited a website, chat-room, message board or other electronic forum containing information or discussion about Digitek®?



Yes ☐ No ☒ If Yes, please provide the name of the website: _____

IV. MEDICAL BACKGROUND

1. Current Height: 
2. Current Weight: 
3. Approximate weight at the time of your injury: 
- 4.A. To the best of your knowledge, have you, or any blood-relative family member (child, parent, brother, sister, or grandparent), ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. For each condition for which you answer **Yes**, please identify who suffered the condition, you or a relative, and please provide the relative's name and relationship to you. If you suffered the condition, please provide the additional information requested in the table following 4(B):

CONDITION EXPERIENCED OR DIAGNOSED	YES	NO	WHO SUFFERED CONDITION
Abnormal heart rhythm, atrial fibrillation, atrial flutter, ventricular fibrillation, or heart block			
Allergic reaction to medication (e.g., skin reaction, rash, or anaphylaxis)			
Blocked or narrow arteries/plaque buildup/coronary artery disease			
Cardiomyopathy/enlarged heart			
Chest pain/angina			
Congenital heart abnormality			
Congestive heart failure			
Heart attack/MI/myocardial infarction			
High blood pressure/hypertension			
High cholesterol or triglycerides			
Kidney disease or condition			
Stroke/transient ischemic attack/TIA/aneurysm			

- 4.B. To the best of your knowledge, have you ever experienced or been diagnosed with any of the following conditions? Please select **Yes** or **No** for each condition. If you suffered the condition, please provide the additional information requested in the table following this chart:

CONDITION EXPERIENCED OR DIAGNOSED	YES	NO
Alcoholism or other substance abuse		
Alzheimer's, senility, confusion		
Arthritis (osteoarthritis or rheumatoid arthritis)		
Autoimmune diseases (e.g., rheumatoid arthritis, lupus, Sjogren's, etc.)		
Bleeding or clotting disorders		
Cancer		
Chronic obstructive pulmonary disease/COPD/chronic lung disease/asthma		
Deep vein thrombosis/DVT		
Depression, anxiety, schizophrenia, bipolar disorder		
Dermatologic diseases or conditions		
Diabetes mellitus		
Electrolyte imbalance		
Enlarged prostate, bladder dysfunction		
Gastrointestinal problems (e.g., ulcers, heartburn, acid		

CONDITION EXPERIENCED OR DIAGNOSED	YES	NO
reflux, GERD, increased or decreased motility)		
Hardening of the arteries/stenosis/aneurysms		
Heart valve problems (e.g., murmur, leaky valve, prolapse, regurgitation)		
Hormonal replacement therapy		
Hypothyroidism/Thyroid condition		
Immune system disease or dysfunction (including HIV or AIDS)		
Liver disorder or disease (cirrhosis, hepatitis, etc.)		
Multiple sclerosis, myasthenia gravis		
Osteoporosis, bone fractures, calcium deficiency		
Peripheral vascular disease or peripheral arterial disease		
Pulmonary embolism/blood clot to the lungs		
Pulmonary hypertension		
Raynaud's syndrome/phenomenon		
Rheumatic Fever/Scarlet Fever		
Tobacco use or addiction		
Vasculitis		

For each condition for which you answered **Yes** in the previous two charts, please provide the information requested below:

[illegible]

CONDITION YOU EXPERIENCED	DATE OF ONSET	MEDICATION/TREATMENT	TREATING PHYSICIAN AND/OR HOSPITAL

5. Please indicate whether you have ever been the subject of any **cardiovascular surgeries** including, but not limited to, open heart/bypass surgery, CABG, pacemaker or defibrillator implantation, stent placement, vascular surgery, angioplasty, IVC filter placement, carotid (neck) surgery, or valve replacement.

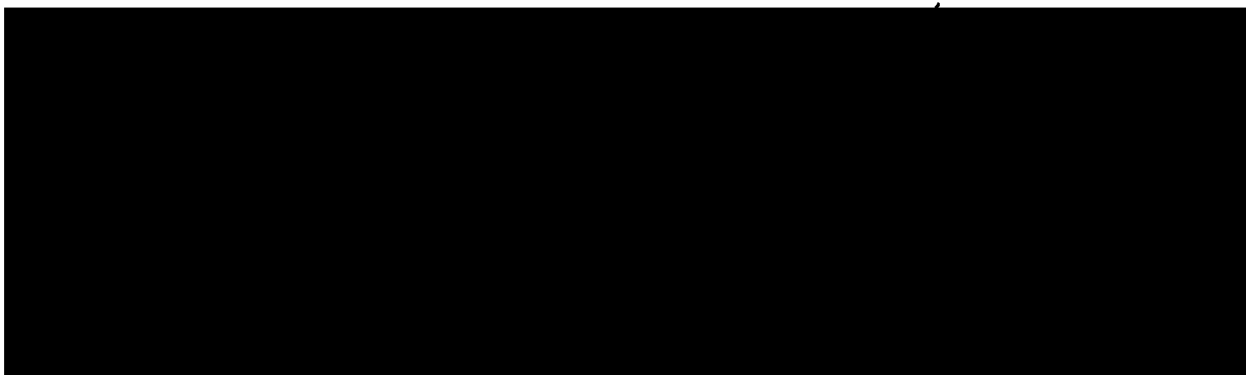
6. Please indicate whether you have ever been the subject of any of the following **cardiovascular diagnostic tests** or interventions and provide the requested information about each: including, but not limited to, stress test C-reactive protein (CRP); chest X-ray; angiogram/catheterization; CT scan; MRI; EKG; echocardiogram; TEE (trans-esophageal echo); endoscopy; lung bronchoscopy; carotid duplex/ultrasound; MRI/MRA of the head/neck; angiogram of the head/neck; CT scan of the head; bubble/microbubble study; and Holter monitor.

V. ADDITIONAL MEDICATIONS
(INCLUDING OTHER DIGOXIN PRODUCTS, SUCH AS LANOXIN®)

[illegible]

NAME OF MEDICATION USED	DOSAGE	PRESCRIBING PHYSICIAN	DATES OF USE	PURPOSE OF PRESCRIPTION

2.



VI. PERSONAL INFORMATION

1. Current Address and Date when you began living at this address: [REDACTED]
[REDACTED]

2. Social Security Number: [REDACTED]

3. Date and Place of Birth: [REDACTED]

4. Marital Status: Married

If married, spouse's name, occupation and date of marriage: [REDACTED]

If divorced, dates of the marriage, case name/jurisdiction for the divorce: _____

Has your spouse filed a loss of consortium in this action? Yes ☒ No ☐

5. If you have children, please list each child's name and date of birth:

[REDACTED]

6. For any school attended after High School, please provide the following information:

a. School Name: Delaware Valley College

b. Address: 700 E. Butler Avenue, Doylestown, PA 18901

c. Dates attended: Graduated 1973

d. Diploma/Degree: BA Science

7. Employment information for the last ten (10) years. Please include employer's name, address, dates of employment, job title, job description and duties:

Self-employed, [REDACTED]

8. Have you ever served in the military, including the military reserve or National Guard?

Yes ☐ No ☒

If Yes, were you ever rejected or discharged from military service for any reason relating to your physical condition? Yes ☐ No ☐

If Yes, state the condition for which you were rejected or discharged: _____

9. Has any insurance or other company, or Medicare or Medicaid, provided medical coverage to you or paid medical bills on your behalf in the last ten (10) years?

Yes ☒ No ☐ If Yes, please specify the following:

- a. The name of the company/agency: AmeriHealth
 b. Address: PO Box 997, Horsham, PA 19044-0997
 c. Dates of Service: 1995 to present

10. Have you applied for workers' compensation (WC) and/or social security disability (SSI or SSD) benefits in the last ten (10) years?

Yes ☒ No ☐ If Yes, please specify the following:

- a. Type of claim: SSD
 b. Year application filed: Plaintiff does not recall
 c. Agency where application was filed: Plaintiff does not recall
 d. Nature of disability: N/A
 e. Time period of disability: N/A

11. Have you filed a lawsuit or made a claim in the last ten (10) years, other than in the present suit, relating to any bodily injury?

Yes ☐ No ☒ If Yes, please specify the following:

- a. Court in which suit/claim filed or made: _____
 b. Case/Claim Number: _____
 c. Nature of Claim/Injury: _____

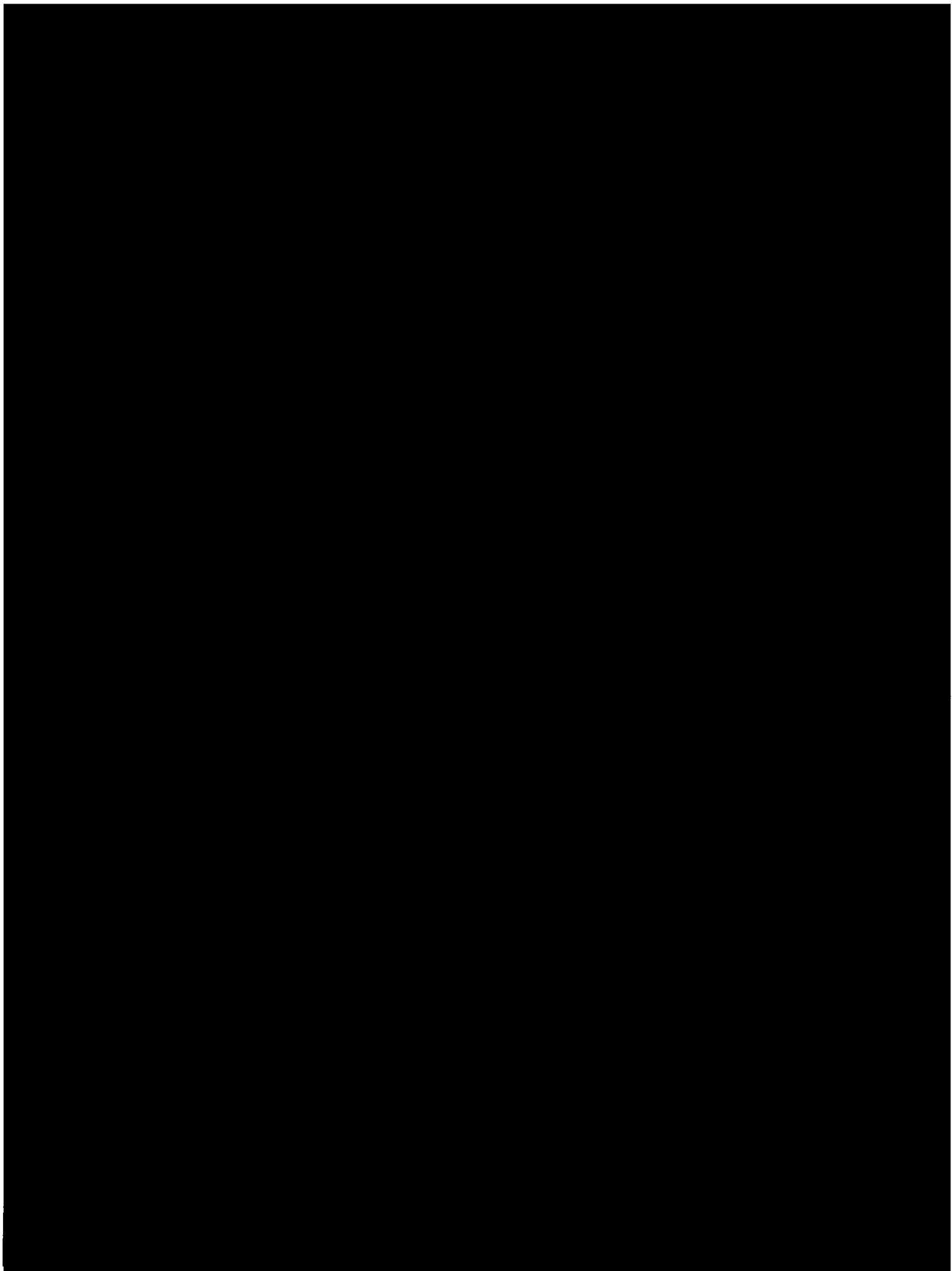
12. As an adult, have you been convicted of, or plead guilty to, a felony and/or crime of fraud or dishonesty?

Yes ☐ No ☒ If Yes, please set forth where, when and the felony and/or crime: _____

VII. HEALTHCARE PROVIDERS AND PHARMACIES

1. Identify each doctor or other healthcare provider who you have seen for medical care and treatment in the past ten (10) years:

NAME AND SPECIALTY	ADDRESS	REASON FOR VISIT	APPROX DATES/YEARS OF VISITS



VIII. DECEASED INDIVIDUALS AND AUTOPSY INFORMATION

1. If you are filling this out on behalf of an individual who is deceased, please state the following from the Death Certificate of the individual:

(NOTE: In lieu of the following, please attach a copy of the death certificate.)

Date of death: _____
Place of death (city, state and county): _____
Facility or location where death occurred: _____
Name of physician who signed death certificate: _____
Cause of death: _____

If you are filling this out on behalf of an individual who is deceased and on whom an autopsy was performed, please fill in the information below pertaining to the autopsy and the autopsy report:

(NOTE: In lieu of the following, please attach a copy of the autopsy report.)

Date: _____
Performed by: _____
Facility where autopsy was performed: _____
Place where autopsy was performed (city, state, county): _____
Describe any and all tissue preserved: _____

IX. FACT WITNESSES

1. Please identify all persons who you believe possess information concerning your injury(ies) and current medical conditions, other than your healthcare providers, and please state their name address and his/her/their relationship to you:

Name: _____
Address: _____
Relationship to you: _____

Name: _____
Address: _____
Relationship to you: _____

Name: _____
Address: _____
Relationship to you: _____

Name: _____
Address: _____
Relationship to you: _____

Name: _____
Address: _____
Relationship to you: _____

IX. DOCUMENT DEMANDS

1. Authorizations: please sign authorizations that are attached hereto as Exhibit A, for each of the healthcare providers that you have identified above in your Answers to §II, Question Nos. 1-3, and § IV, Question No. 2.
2. Documents in your possession, including writings on paper or in electronic form: If you have any of the following materials in your custody or possession, please attach a copy to this Fact Sheet.
 - a. All documents constituting, concerning or relating to product use instructions, product warnings, package inserts, pharmacy handouts or other materials distributed with or provided to you in connection with your use of Digitek®.
 - b. Copies of the entire packaging, including the box and label, for Digitek® and any Digitek® tablets (plaintiffs or their counsel must maintain the originals of the items requested in this subpart).
 - c. All documents relating to your purchase of Digitek®, including, but not limited to, receipts, prescriptions or records of purchase.
 - d. All photographs, drawing, journals, slides, videos, DVDs or any other media relating to your alleged injury.
 - e. Copies of letters testamentary or letters of administration relating to your status as plaintiff (if applicable).
 - f. Decedent's death certificate and autopsy report (if applicable).
 - g. Medical records, bills, correspondence, reports and all other documents from any health care provider who saw, evaluated or treated Plaintiff/Decedent in the last five (5) years.
 - h. All emergency responder, paramedic or EMT reports regarding Plaintiff/Decedent.
 - i. Documents concerning any communication between Plaintiff/Decedent or Plaintiff/Decedent's attorneys or agents and the FDA or any Defendant regarding the events giving rise to the lawsuit or relating to Digitek.
 - j. Non-privileged documents, including any diaries, calendars or notes that record Plaintiff/Decedent's health, use of Digitek or alleged injuries

X. VERIFICATION

I declare under penalty of perjury that all of the information provided in this Plaintiff Fact Sheet is true and correct to the best of my knowledge. I have supplied all the documents requested in Part ____ of this declaration, to the extent that such documents are in my possession, custody, or control, or in the possession, custody, or control of my lawyers, and supplied the authorizations attached to this declaration.

Further, I acknowledge that I have an obligation to supplement the above responses if I learn that they are in any material respects incomplete or incorrect.

Date: 8/13/09

Signature